TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Eradio Arredondo, M.D.

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-17-0436-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
October 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS"

Amount in Dispute: $1,150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office received an initial medical bill on 12/29/2015 for dates of service 12/18/2015, whereas upon completion of a clean claim review it was determined that the provider did not complete Section 21 Box A and did not complete the ICD indicator box as required. The bill was returned to the provider on 1/6/2016 with a letter educating the provider that for dates of service prior to 10/1/2015 the billing must reflect the required ICD-9 or ICD-10 codes."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2015	Designated Doctor Examination	$1,150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 defines a complete medical bill.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
4. 28 Texas Administrative Code §133.200 defines the actions required of the insurance carrier upon receipt of a medical bill.

5. Documentation for this dispute did not include an explanation of benefits.

Issues

Did Eradio Arredondo, M.D. submit a complete medical bill to the insurance carrier in accordance with 28 Texas Administrative Codes §§133.10 and 133.20?

Findings

Eradio Arredondo, M.D. is seeking reimbursement of $1,150.00 for a designated doctor examination performed on December 18, 2015. Review of the submitted documentation finds the following:

- On or about December 29, 2015, Dr. Arredondo submitted a medical bill for the disputed services.
- In a letter dated January 6, 2016, the State Office of Risk Management rejected the submitted bill, stating "For dates of service on or after 10/01/2015 ICD-10s are required to be billed … ICD Indicator 10 is required for dates of service on or after 10/01/15."
- A fax confirmation dated January 14, 2016 indicates that a corrected medical bill was submitted to the State Office of Risk Management at the fax number provided on the Request for Designated Doctor Examination (DWC032).

The division finds that, while the State Office of Risk Management failed to evaluate the new medical bill for completeness in accordance with 28 Texas Administrative Code §133.200, the CMS-1500 submitted was incomplete. 28 Texas Administrative Code §133.10(f)(1)(M) states that a "diagnosis or nature of injury (CMS-1500/field 21) is required, at least one diagnosis code and **the applicable ICD indicator must be present** [emphasis added]…" The new medical bill submitted on January 14, 2016 included a diagnosis code in field 21A, but did not include the required ICD indicator.

28 Texas Administrative Code §133.307 requires that, prior to requesting medical fee dispute resolution, the requestor is obligated to submit a complete medical bill in accordance with 28 Texas Administrative Code §133.10 to the insurance carrier within 95 days from the date of service, as required by 28 Texas Administrative Code §133.20. The division concludes the Dr. Arredondo did not submit a complete medical bill to the insurance carrier in accordance with 28 Texas Administrative Codes §§133.10 and 133.20. Therefore, no reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	November 16, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.